REPORT OF TARGET EXAMINATION
Clark United Providers
As of May 20, 1996

Clark United Providers

CHIEF EXAMINER'S AFFIDAVIT

I certify that I have reviewed the Report of the Target Examination of CLARK UNITED PROVIDERS of Vancouver, Washington as of May 20, 1996.

JACQUELINE L. GARDNER, CFE, FLMI
Chief Examiner

4/23/97

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To:	**Jacqueline L. Gardner, CFE, FLMI** **Chief Insurance Examiner**
From:	**Michael V. Jordan, CPA, CFE** **Examiner in Charge**
Subject:	**Target Examination of Clark United Providers**
Date:	**June 13, 1996**
Examination Team:	**Michael Jordan, CPA, CFE, Examiner in Charge** **Leslie Krier, FLMI, Market Conduct Examiner** **Frank Ebero, FLMI, AFE, Financial Examiner**

Pursuant to your instructions and in compliance with the requirements of the state of Washington, a target examination has been made of the corporate affairs and financial records of Clark United Providers of Vancouver, Washington, hereafter referred to as the Company at its home office located at 505 NE 87th Ave, Suite 47, Vancouver, Washington 98668.

The Objectives of our target examination were as follows:

1. Review and assess quality of management.
2. Determine the adequacy of internal controls and the reliance that can be placed on the Company's accounts and records.
3. Assess the Controls in place for Electronic Data Processing systems (EDP).
4. Review and assess operations for compliance with state regulations pertaining to consumer policy and benefits.
5. Review Company compliance with Washington State statutes and National Association of Insurance Commissioners (NAIC) regulations pertaining to the compilation and reporting of the annual statement.
6. Gain a level of comfort for overall ability and expertise in health care operations.
7. Review correspondence between the Office of the Insurance Commissioner (OIC) and the Company to determine areas in need of closer review and analysis.

Scope

Our target examination included the business affairs and financial condition of the Company for the period ended May 20, 1996. The examination was performed in accordance with procedures promulgated by the NAIC for limited scope examinations and in compliance with the provisions of Washington State insurance laws and regulations.

Findings and Instructions

1. Administrative Contracts

Clark United Providers

The agreement between Southwest Washington Medical Center (SWMC) and the Company is very cursory and does not specifically define the services rendered but rather states in general terms the services to be provided and the methodology of reimbursement. The Company is instructed to revise the administrative contract to specifically detail the types of services provided and methodology of payment such as terms and settlements.

During our review, it was noted the Company has been operating under an contract with PacifiCare of Oregon, Inc., since February of 1995, for the use of the Company's provider network. The contract has never been formalized with the appropriate signatures. It is recommended that the Company formalize the agreement with PacifiCare of Oregon, Inc., as soon as possible.

2. Member Contracts

All member handbooks and contracts must be filed with the OIC prior to use, unless the contract is negotiated. In this case, they must be filed within 30 working days of the end of negotiations. Revised Code of Washington (RCW) 48.44.040 and Washington Administrative Code (WAC) 284-44-130(1) require that these be filed prior to use. The Company has not filed any member contracts or handbooks for plans they sell. This includes Basic Health Plan (BHP), Healthy Options, and SSI (Medicaid) plans. The Company is instructed to file member contracts per RCW 48.44.040 and WAC 284-44-130(1).

As of January 1, 1995, all companies that sell individual plans must have a BHP look alike contract available on a direct, individual basis per RCW 48.44.022. The Company does not have this product. At this time, the Company only sells BHP, Healthy Options, and SSI coverage. If they expand into the commercial market, a BHP look alike contract will be required.

3. Provider Contracts

The Company currently lists providers in their provider listing that are not contracted. The Company needs to develop and maintain a complete listing of providers to be distributed to members at the time of enrollment, and as changes occur. This list is to contain only those providers who have a direct contract with the Company or who are part of a network formally rented by the Company as set forth in RCW 48.44.080. This requirement also applies to the All Categories of Providers listing filed with OIC.

At this time, the Company relies on ancillary services provided by the hospital (SWMC). This arrangement needs to be formalized, or the Company must cease listing this class of provider as part of the Company's network.

The contract with Hi-School Pharmacy deviates from the provider contract(s) filed with OIC in that

it does not contain the mandated hold harmless and insolvency language. This contract must be revised to contain WAC 284-44-240 mandated language, and must be filed with OIC.

The Referral Provider Agreement (PA-3) contains an election page for the provider to chose either "capitated" payment or "non-capitated" payment. These terms actually refer to a type of payment plan rather than a capitated/non-capitated contract type. This page needs to be revised to reflect the intent of the contract by rewording the election items, and by defining the terms used on this page in the Definitions section of the contract.

Several other provider contract deficiencies were noted. The Company is instructed to correct the following deficiencies:

a. The generic provider type is used in place of a provider name. In some cases, the provider is never identified in the contract. The generic term needs to be replaced with the provider's name.

b. Section 2.13 needs to be revised to indicate the exact responsibility of the provider in dealing with Coordination of Benefits.

c. The term Payor needs to be deleted from Section 6, as this contract is between the provider and the Company, not the provider and the Payor. Insolvency and Hold Harmless provisions need to be addressed in the contract with the Payor.

d. Southwest Washington Medical Direct (SWMD) is a department of the Company. SWMD's name should not be listed as a party to the provider agreement. The name, Southwest Washington Medical Direct, should be deleted from contract headings or other areas where it can be construed that they are a part of the contract.

4. Claim and Disbursement Analysis

Our analysis disclosed that there are no documented control procedures and division of duties for control purposes are very weak or almost non-existent. In addition, claim audits are not conducted, Claim numbers do not allow for tracking hard copies, and denied claims are deleted from the system so they can not be tracked for audit purposes. The Company recently installed a new computer system called the IDX system. This new system will be used to adjudicate and process claim and

other disbursements. The Company has not yet documented control procedures using this new system, but has hired a consultant to review work flows and recommend changes to tighten controls over the claims operations. It was noted during the examination that the system lacks controls and reporting functions that would enhance the claims operation.

The Company is instructed to address the following control weaknesses and integrate the IDX system to support these controls:

a. The claims operation does not perform quality audits or reviews. It is recommended that this be established immediately to ensure that claims are being paid properly and in a timely fashion.

b. There are no formal written claims procedures. These need to be developed immediately, including written procedures for coordination of benefits and subrogation claims.

c. It was noted during our review of the claims processing work flow at the claims unit of SWMD that there is no segregation of duties. It is recommended that the person processing the claims should not have access to the actual payment or mailing of the checks as is now the case.

5. Annual Statement

Review of the 1995 Annual Statement filing disclosed several areas where the Company failed to comply with the NAIC *Annual Statement Instructions for Hospital, Medical and Dental Service or Indemnity Corporations*. The Company is instructed to comply with the NAIC guidelines in all future filings. The following deficiencies were noted:

a. The Company did not report administrative service contract business as required. Administrative service contract premiums and claims should be reported net in the underwriting and investment exhibit and all receivables and payables pertaining to this business should be reported under uninsured accident and health business, on the statement of assets and liabilities, respectively.

b. The Company has reinsurance underwritten by Lloyd's of London for hospital and professional provider specific excess or stop loss. The Company failed to disclose this under Schedule 'S' in their filed 1995 Annual Statement.

c. The Company failed to file form IC-13A-HC, Additional Data to the Annual Statement. The

Company was requested to complete this form during our target examination and was also instructed to immediately file this form with the Insurance Commissioner's Office.

d. The Company improperly compiled schedule DA-Part 1, Short-Term investments. It neglected to include the CUSIP identification and the NAIC designations as required.

6. Subrogation

The Company does not have formal subrogation procedures in place. At this time, the Company does not investigate claims that might be covered under Auto Personal Injury Protection and Worker's Compensation. It is recommended the Company institute formal guidelines for subrogation in order to realize the benefits for themselves and subscribers.

7. Conflict of Interest Questionnaires

The Company requires Officers and Board Members to sign Conflict of Interest policy statements but does not require conflict of interest questionnaires to be attached to the policy statements. Without questionnaires on file, we were unable to determine if there were conflicts and if so, what they were. The Company is instructed to implement conflict of interest questionnaires to be used in conjunction with the policy statements

8. Cash Receipts

There is a lack of segregation of duties for cash receipts. The Chief Accountant makes the deposits, posts the journal entries, receives the bank statements, and reconciles the bank accounts. She also transfers the funds between savings and checking accounts. The Company is instructed to review its cash receipt procedures and develop a system with better controls and segregation of duties.

Conclusion

Based on our limited scope examination, it is in our opinion that the Company needs to be monitored closely during its first years of incorporation. The Company meets the statutorily defined minimum net worth of one million dollars as defined in RCW 48.44.037(2), with a net worth of approximately $1.5 million dollars. Gene Johnson, Chief Financial Officer for the Company, stated that Southwest Washington Medical Center is committed to maintain the statutory minimum surplus required through capital contributions regardless of profitability of the Company.

We are concerned by management's expressed intent to not allow profits to build a surplus above the statutory minimums but instead disburse any profitable margins back to the member providers. In its first year of operations, 1995, the Company lost approximately $500,000, mainly

due to start up costs. Greg Munn, Financial Analyst for the Company, projects a loss of $676,000 for the year ended December 31, 1996. Management also projects the Company will begin generating profits by 1997.

During our review, numerous non-compliance and internal control problems were disclosed through our analysis. The primary or most serious of the problems are disclosed under the Findings section of this report. Additional examination findings are disclosed in the appropriate sections of the report for which they relate. The Company has been very diligent and has operated in the utmost good faith to correct the problems disclosed in this target examination report. Based on our analysis, the Company is a high priority examination and it is recommended they be scheduled for a full scope financial and market conduct examination after the 1996 annual statement is filed.

I. CORPORATE MANAGEMENT AND RECORDS

Company Officers' years of service with the Company

	Elected
Jeffrey Day Selberg, President	1994
Tom Dietrich, M.D., Medical Director	1994
Philip Armstrong, V.P. Operations	1995
Dale Johnson, V.P. Health Plans	1994
Gene Johnson, Chief Financial Officer	1994

Blanket fidelity bond in the amount of $1,000,000, $10,000 deductible

Annual statement review

Review of the 1995 Annual Statement filing disclosed several deficiencies the Company is instructed to correct with future filings. The following is a list of those deficiencies:

1. The Company did not report administrative service contract business as required by the NAIC Annual Statement Instructions. Administrative service contract premiums and claims should be reported net in the underwriting and investment exhibit part 3 line 17. All receivables and payables pertaining to this business should be reported on line 10, uninsured accident and health business, on the statement of assets and liabilities, respectively.

2. The Company has reinsurance underwritten by Lloyd's of London for hospital and professional provider specific excess or stop loss. The Company failed to disclose this under Schedule S in their filed 1995 annual statement as required by the NAIC Annual Statement Instructions.

3. The Company failed to file form IC-13A-HC, Additional Data to the Annual Statement. The

Company was requested to complete this form during our target examination to determine if the required indemnity deposit was sufficient and was also instructed to immediately file this form with the Insurance Commissioner's Office.

4. The Company improperly compiled schedule DA-Part 1, Short-Term investments. It neglected to include the CUSIP identification and the NAIC designations as required by the NAIC Annual Statement Instructions.

Board Minute Review

The Company only markets the Basic Health Plan and Healthy Options. The Company expressed its desire not to market any other products. In 1995, the Company marketed a policy for the Public Employees Benefit Board (PEBB) through the Health Care Authority which received approximately seventeen enrollees. The Company did not bid on PEBB for the 1996 fiscal year. The contract used for the PEBB business was never filed with the Insurance Commissioner. The only contract that has been filed is a conversion type policy.

The Company management states their main interest is in supplying capitated provider networks for other companies. Management believes the company can realize revenue between 5% to 10% of the capitated fees. This would generate its primary source of profits due to the low margins attributable to BHP and Healthy Options.

The Company also expressed its desire to refund to the providers any surplus generated under capitation agreements. In this manner, it would not allow surplus to build and would use the statutory minimum surplus requirements as the desired benchmark. The Company entered into a Special Consent Distribution Agreement dated August 22, 1994 with the Insurance Commissioner where the Company voluntarily agreed to follow all provisions of dividend and distribution payments under RCW 48.31B. This will never be an issue with refunded pool reserves for capitation.

Administrative Contracts

Clark United Providers

Southwest Washington Medical Center (SWMC)

The Company entered into an agreement on September 1, 1993 with Southwest Washington Medical Center. The agreement states that SWMC will provide human resource services for Clark United Providers (CUP). The costs of these services will be billed to CUP for actual costs paid and accrued. SWMC may also provide other payroll related service and some non-payroll services and supplies that will be billed to CUP on the basis of actual costs incurred.

Reinsurance Contract

The Company has obtained reinsurance or stop loss coverage underwritten by Lloyd's of London. The contract has been in force since the inception of the Company and the Company intends to maintain this coverage in the future. The contract provides the following coverage:

Limit:	$1,000,000 hospital per member per annum $100,000 professional per member per annum	
Excess:	Hospital	$100,000
	Professional	$ 10,000

Special Consent Distribution Agreement

This agreement is between Clark United Providers and the Office of the Insurance Commissioner/State of Washington. It was entered into on August 22, 1994. The purpose of this agreement is to assure that the Company will obtain prior approval from the OIC prior to payment of dividends or distributions of net earnings.

PacifiCare of Oregon, Inc. Health Services Agreement

This draft agreement is between Clark United Providers and PacifiCare of Oregon, Inc. The purpose of the agreement is to describe the services to be provided by the Company to PacifiCare. These consist of the rental of the CUP provider network to PacifiCare and a type of third party administration agreement for PacifiCare Medicare business in the CUP service area. The agreement is still in draft form, but actual services were provided as of January 1995. The agreement describes the services to be provided to PacifiCare for network maintenance, utilization management, administration, and claim adjudication.

Agreement to Consolidate Managed Care Offices

This agreement covers the integration of managed care administration for three entities, Vancouver

Clinic (VC), Family Physicians Group (FPG) and Clark United Physicians (CUP). The agreement was signed mid-November 1995 by all parties. The agreement outlines management of the office, staffing plans, and allocable costs. It includes procedures and rules for sharing common costs among the parties to the agreement.

Washington State Health Care Authority

This agreement was entered into by the Washington State Health Care Authority and Clark United Providers on January 1, 1995 for the purpose of allowing the Company to provide Basic Health Plan and Basic Health Plan Plus benefits to enrollees in these plans. The contract describes Definitions, Eligibility and Enrollment Procedures, Termination Provisions, Monthly Fees, and General Administration. In addition, an attached schedule states the benefit, exclusions and limitations to be included in this coverage. A separate amendment expands coverage to include the Basic Health Plan Plus.

Washington State Department of Social and Health Services

The purpose of this contract is to allow the Company to provide Healthy Options coverage for eligible persons in the Clark County area. The contract was effective for services from March 1, 1995 and ends December 31, 1996. The contract outlines services to be performed by the Company, and sets guidelines for standard of care, benefits to be provided, and administrative functions to be performed by the Company. It also includes a fee schedule.

II. Financial Findings and Comments

Fluctuation Analysis

The objective of this examination for Fluctuation Analysis is to review the Financial Statements of the period under examination for any unusual variances in reported balances between years and then determine if there is a reasonable explanation for the variance.

The examination will review the Company's Financial Statements for 1994 and 1995, the only years the Company has filed. A questionnaire was submitted to the Company's Financial Analyst, Greg Munn, for explanation of the variances. The explanations provided by the Company appear to reasonably explain the variances in the reported balances between years.

Clark United Providers

Receipt Analysis

Receipts include capitation payments from the Health Care Authority and Department of Social and Health Services for BHP and Healthy Options, respectively. In addition, receipts include payments from various insurance entities for use of the Company's provider network and monies for membership dues by providers.

The Company does not have an automated system for handling cash receipts. Cash receipts are routed to the Managed Care Office (MCO) of SWMC where they are sorted. Premiums for Clark United Providers are forwarded to the Chief Accountant of the Accounting Department of Southwest Washington Medical Center. When the Chief Accountant receives the checks from MCO, she prepares a deposit slip for the bank. These checks are deposited to a savings account with Northwest National Bank. The checking account balance is maintained at a level high enough to pay current disbursements. The accounts payable clerk of SWMC processes checks twice a week. She notifies the Chief Accountant of the total amount of checks issued for the day. Based on that information, the Chief Accountant will determine if there is enough money in the checking account. If the checking account is deficient in funds, the Chief Accountant transfers money from the savings account to the checking account. As of December 31, 1995, the checking account balance was $9,706 while the savings account balance was $218,018.

A sample of five (5) cash receipts were selected for review. Copies of deposit slips and copies of the checks attached were reviewed. The deposits were traced to the bank statement without exception. Transfer of funds from the savings account to the checking account were also verified to the bank statement.

Journal entries were reviewed for these five (5) cash receipts transactions. The Chief Accountant debited Cash on Deposit and credited Premium Revenue, Participating Providers Fee, Capital-Class A members, and other accounts. These entries were traced to the general ledger without exception.

Reconciliation of the bank statement is done monthly, also by the Chief Accountant. We reviewed the reconciliations for two months and noted no unusual exceptions. Most of the reconciling items were outstanding checks. The savings account bank balance agreed with the general ledger.

Conclusion

There is a lack of segregation of duties for cash receipts. The Chief Accountant makes the deposits, posts the journal entries, receives the bank statements, and reconciles the bank accounts. She also transfers the funds between savings and checking accounts. We strongly recommend the Company review its cash receipt procedures and develop a system with better controls and segregation of

duties.

Disbursement Analysis

The disbursement analysis includes claims, capitation, and administrative payments.

Claim Disbursements

Claims come directly to Southwest Washington Medical Direct (SWMD) from the various clinics and providers; Vancouver Clinic, Family Medicine, Pacific Care, non-contracted referrals, and out of area.

Claims are then sent to the Claims Unit and logged into the IDX system for adjudication and proper payment. A Cash Requirement Report is then produced and sent to Greg Munn for review against the various pools to assess the Company's ability to pay. Instructions are given on the report as to the percentage of payment which will be made. The report is then returned to the Claims Unit for payment. Checks are then processed and mailed to the payees by the Claims Unit.

Checks are processed once a month at the Claims Unit of SWMD. A list of checks processed from the IDX system are then forwarded to the Chief Accountant of the Accounting Department of SWMC who makes a manual entry into a clearing account of the general ledger of the Company. Only the total of such payments appear in the general ledger.

A sample of four (4) claims paid were selected from the claims listing provided by the Company. Copies of checks paid and other supporting documents for these claims were obtained from the Claims Unit of SWMD. These claims were traced to the clearing account and general ledger of the Company without exception.

Clark United Providers

Capitation and Administrative Payments

The Company uses an accounting system called Enterprise System Inc. (ESI), for its capitation and administrative disbursements.

The controls in place for checks prepared through the accounting system are:

- Vouchers are reviewed and approved by any of the following authorized officers of the Company: Gene Johnson, Philip Armstrong or Greg Munn. When approved the vouchers are then forwarded to accounts payable for payments. For capitation payments, a report (Revenues Accounting Transmittal) from SWMC, is the source document for payment.

- The accounts payable department verifies that the voucher has the appropriate approval and codes the voucher for input into the accounting system.

- The vouchers are input in the accounting system and checks are processed twice a week by accounts payable on Tuesdays and Thursdays and more often if necessary.

- All checks are then verified against the original vouchers for administrative disbursements or against the list provided by SWMC for capitation payments. If the amount of the check agrees with the voucher or list, the check is then mailed to the payee.

- If the check is for $25,000 or more, the check must be countersigned by Philip Armstrong, Vice President, Operations or Gene Johnson, Chief Financial Officer.

Disbursement Sample

A sample of three (3) administrative expense vouchers and two (2) capitation payments were judgmentally selected for review to determine if the internal controls for disbursements were being followed. The following items were noted:

- All three (3) administrative expense vouchers were properly authorized. When the checks are processed, a copy of the check marked "COPY" is also printed. The check "COPY" is attached to the voucher and the voucher marked "PAID" with the date of payment. The two (2) capitation payments were verified against the list provided by SWMC without exception. A copy of the check is attached to the list and marked paid with the date of payment and initialed by Lorna Cass of accounts payable. The payments were traced to a Distribution Report that listed payments for the day. The total amount of the report is coded to different classifications of payments and an entry is made to the general ledger. The entries were traced to the general ledger without exception.

Conclusion

The controls in place for claims disbursements appear to be inadequate. It was noted during our review of the claims processing work flow at the Claims Unit of SWMD, that there is no segregation of duties. It is recommended that the person processing the claims should not have access to the actual payment or mailing of the checks as is now the case.

For capitation and administrative payments, the controls are adequate and the Company appears to follow the controls in place.

Investment Analysis

The Company's investment portfolio consists only of Short-term Investments of United States Treasury Bills on deposit with Northwest National Bank in Vancouver, Washington. These investments accounted for 87% and 90% of total assets in 1994 and 1995, respectively.

According to Anita Williams, Controller, SWMC, these short-term investments were confirmed by the Company's CPA's, Moss Adams, LLP, without exception.

RCW 48.13.260 requires an insurer to invest and keep invested its funds aggregating in amount of not less than 100% of its minimum net worth in public obligations per RCW 48.13.040. The Company had a minimum net worth of $1,500,000 in 1994 and $1,000,000 in 1995. The Company had investments in US Treasury Bills of $1,501,346 in 1994 and $2,484,584 in 1995, which was in compliance with the above codes.

A review of the Board of Directors minutes determined that the directors do not approve the purchase and sale of securities as required by RCW 48.13.340, which states:

> "No investment, loan, sale or exchange thereof shall, except as to the policy loans of a life insurer, be made by any domestic insurer unless authorized or approved by its board of directors or by a committee charged by the board of directors or the bylaws with the duty of making such investment, loan, sale or exchange. The minutes of any such committee shall be recorded and reports thereof shall be submitted to the board of directors for approval or disapproval."

Schedule DA - Part 2 of the Annual Statement showed short-term investments acquired and disposed of during the year which were not approved by the Board of Directors. This was brought to the attention of Gene Johnson, CFO, who agreed that in the future, investment transactions will be presented to the Board of Directors for their approval or disapproval.

Securities on Deposit

RCW 48.44.030 requires a Health Care Service Contractor to place securities on deposit with the state of Washington in the amount equal to the greater of $150,000 or the amount necessary to cover Incurred But Unpaid Reimbursements. The Company does not have a security deposit, but lists an Indemnity Bond for $150,000 with Safeco Insurance Company of America which is in compliance with the above code.

Safekeeping Agreements

According to Gene Johnson, CFO, the Company has a custodial agreement with Northwest National Bank for the securities listed in its investment portfolio. The agreement was not reviewed for compliance to the NAIC guidelines, but should be reviewed in a regular full scope examination.

Conclusion

Based on the work performed and information provided, the controls in place for investments appear to be adequate. However, the following recommendation is made:

1. It is recommended that purchases and sales of securities be approved by the Board of Directors as required by RCW 48.13.340.

Claim Reserves

The Company was unable to produce a report on claims incurred and paid (run-off) for 1995 incurred claims to test the adequacy of the unpaid claim liability. According to Lew Orsi, Moss Adams, LLP, was able to test the unpaid claim liability and were reasonably assured that the liability established in the 1995 Annual Statement was adequate. For the purposes of this target examination we will rely upon the work performed by Moss Adams, LLP.

Contingent Liabilities

The Company entered into a guaranteed lease commitment of real property for a medical clinic owned by certain contracted providers in Camas, Washington. The lease term is ten years with a total remaining minimum lease obligation of $902,400 as of December 31, 1995.

No other contingent liabilities were disclosed by the Company.

III. MARKET CONDUCT

Claims Compliance Testing

Clark United Providers

Claims are handled by Southwest Washington Medical Direct (SWMD). Submitted claims are routed to a clerk to input summary data in order to assign a claim number and to allocate certain provider claims to the appropriate claims processors. The claim processor then logs in additional information relevant to the adjudication process. The Company had a new claims system, IDX, installed during the first quarter of 1996. During this time, capitated payments were made to providers, but no other payments were made.

The IDX system contains a module for eligibility. The system does an on-line edit and comes back immediately and tells the processor if a person is not eligible. The processing is terminated at this point.

The processor inputs the specific claim information, including service dates, diagnosis codes and procedure codes, and provider information. The system does on-line edits, including cross checking diagnosis and procedure codes to determine if they are compatible. If not, the system returns an error message to the processor and adjudication stops until further investigation can be done.

The system automatically assigns a claim number on input. This number is not transferred to the paper claim form. Therefore, matching claims to system information is difficult. Also, the claim can be deleted from the system, which destroys any record of that claim number. This can be done at any time during the adjudication process. While reviewing one file, it was noted that a claim had not been processed on the system, but was with the completed claims. The processor did not know if it had been on the system and deleted, or had just not been processed. The Company needs a control point to ensure that all claims received are added to the system, and are adjudicated to some final action.

The system also checks to see if a referral is in place for the claim. If not, the claim is pended and routed to the Managed Care Unit for review. The system is not programmed to produce a detail report showing pended claims, how long the claim was pended, who pended, the reason it was pended, where the file was sent, etc. The system also is not programmed to produce an aged claim report, which would be a summary report of the detail pended claim listing. The system has few edits and allows processors to override system edits. The system does not produce a report to show these transactions, thus the transactions are not monitored by management.

The claims personnel are knowledgeable about the claims procedures and systems, however, there are no written procedures to establish standards. In addition, there is not a claim audit function, either via system or manually, at this time. The Company needs to establish written claim procedure

manuals and develop claim audit procedures.

The claim review consisted of twenty claims requested at random from a company produced list of claims received during January and February 1996 for Healthy Options subscribers. The list included the name of the claimant, date of service, date of receipt and final action payment. The status on all claims was approved. Checks for this block of claims were produced in the May and June 1996 runs. The Company is behind in claim processing because of the new computer system installation. Of the twenty claims requested, the following statistics apply:

1. The Company was not able to produce two claim forms. They were "lost". In addition, one of these claims did not produce a check as expected. This was found during our review and would not have been caught had we not asked to see the claim form.

2. Five claims were denied by the Company. For four of these, the claim form was not available, as Company procedure calls for the form to be returned to the provider if the benefit was denied. In addition, no system record exists for these denied claims.

3. Four of the claims were recorded as Primary Care Physician (PCP) encounters only. The information is on the system, but the claim forms are not kept in the unit, but sent to storage immediately after input.

4. The other claims reviewed were determined to be appropriately entered into the system and payment made per contract.

5. Time service statistics for this block of business are:

Incurred to Paid:	87.1 days
Received to Paid:	49.7 days

   The reason for this time delay is that during the first quarter, claims were held in order to get the new system up and running. The Company is currently working to reduce the backlog. The Company verbally indicated that the standard will be about ten working days from date of receipt to payment date.

6. One claim was adjusted. The claim had been paid, reversed and then repaid at the same amounts, to the same provider. The Company did not have any documentation as to why this was done, and could not figure out from the on-line information what transactions had occurred or why they had been done. The system does not require a reason code to be entered for the reversal, and adjustments are not reported.

7. One claim was denied because the service performed was not a covered benefit. When this occurs, a notification is sent to the provider only.

8. No coordination of benefits or subrogation claims were in this sample.

Coordination of Benefits (COB) and Subrogation Processing

COB and Subrogation are handled by the claims unit. No formal procedures are in place for either and the following describes the current practice:

COB:

According to the Company, it processes COB on a "pay and chase" basis. Once the Company knows about other insurance, they pursue obtaining the payment information from the provider or the other company. Once received, the system calculates the amount payable and the amount to accrue to savings. This is done by the system for each procedure listed on the claim form.

However, no formal means of accumulating COB savings for each member exists. Each time a claim is received, the processor must go through the entire year's claims for that member, do a manual calculation to determine the current COB savings bank, calculate the current claim amount payable, and apply amounts from savings if applicable. This information is not kept by CUP, so must be recalculated for each subsequent claim. The processor does appear to have a good working knowledge of COB regulations and requirements, and has a copy of WAC 284-51 at her desk for reference.

Subrogation:

Currently, the Company does not actively pursue any type of subrogation benefits. Company personnel, have no record of the Company ever having made a subrogation claim. In addition, it does not investigate any type of claim for other insurance available, but relies solely on the provider information on the claim form. The system contains no edit for certain diagnosis or procedure codes which would indicate third party liability. The sample reviewed, contained two claims, one for carpal tunnel syndrome and one for lower back pain, each of which could indicate on-the-job injuries eligible for Labor and Industries State Industrial coverage. However, no additional information was requested.

Conclusion

In summary, the Company has inadequate controls over the claims operation. It does not track claims received, claims paid, or the current claim status. It has knowledgeable employees with experience in claims processing. We recommend that the Company change or develop the following items to gain control of the claims operation:

1. Claims entered on the system need to have a final action on the system. If the claim is deleted, it should carry a delete status, and this should be counted as a final action.

2. A weekly report is needed to show the status of all claims in the system: logged, pended, approved, paid, deleted, denied. The report should be reconciled monthly to determine the number of claims received, the number of claims still in the system, and the number where a final action has occurred.

3. A monthly aged claims report is needed to determine which claims are pending in the system longer than the established standard, and to assure that all claims are reviewed in a timely fashion.

4. System edits are needed to control processor actions and to ensure that actions are recorded and reported.

5. Adjustments need to be documented with a message/reason code on the system, and files need to be documented so that the adjustment transactions are traceable and reasons are available.

6. The claim number needs to be written on the claim form for file documentation purposes.

7. Denied claims need to remain on the system in a denied status. In addition, the paper trail (claim form) should be maintained by the Company and a copy returned to the provider.

8. The Company needs to institute a claim audit and quality assurance program, and to review claims on a regular basis for each processor.

9. Procedures for all claims steps need to be written and maintained. This sets a standard for claims processing, which is now lacking.

10. The Company needs to write Coordination of Benefit procedures. These procedures need to include a section on how to manually calculate and store savings information for use with the next claim.

11. The Company needs to develop and maintain procedures for handling possible subrogation cases. Lack of this step could be costing the Company claims dollars as they are paying for services actually covered by another entity.

12. System overrides need to be reported. In addition, overrides should be classified by severity and security set up so that only specific individuals have access to override capabilities. Override reports need to be reviewed by management to assure that the transaction is appropriate.

Member Contracts

The Company sells only Basic Health Plan (BHP), Healthy Options, and Medicaid (SSI) plans. Examiners reviewed the member handbooks for BHP and Healthy Options during this examination. These are the only contracts marketed by the Company. Both of these handbooks were designed to tell the subscriber how to use the program, rather than what the program covers. The Company does have three versions of a conversion contract, but does not actively market these products.

1. The Company has not filed any member contracts or handbooks for plans it sells. This includes BHP, Healthy Options, and SSI. RCW 48.44.040 and WAC 284-44-130(1) require that these be filed prior to use.

2. The Healthy Options Member Handbook does not contain a list of excluded or limited benefits, which is required by WAC 284-44-030(2). In addition, the form number is not in the lower left corner of each page as required under WAC 284-44-030(3).

3. Several mandated coverages are not specifically mentioned in the Member Handbook. These are:

RCW 48.44.330	Reconstructive Breast Surgery to the non-diseased breast after a mastectomy
RCW 48.44.325	Benefit for a mammogram
RCW 48.44.212	Benefit for congenital anomalies from birth
RCW 48.44.440	Coverage for PKU
RCW 48.44.450	Treatment of neurodevelopmental therapies for children under age 6
RCW 48.44.344	Benefit for prenatal diagnosis of congenital disorders
WAC 284-44-043	Experimental and Investigational Treatments

Coverage for the above is implied because these benefits are not excluded or limited. The Company needs to specifically state whether or not the benefit is covered.

Rate and Form Filings

All contracts, handbooks, and rates must be filed with the Insurance Commissioner prior to use, as required by RCW 48.44.040 - "...No registrant shall change any rates, modify any contract or offer any new contract until he has filed a copy of the changed rate schedule, modified contract or new contract with the insurance commissioner. ..." and WAC 284-44-130(1) - "..every contract rider or endorsement form and any modifications thereof, and every rate schedule and any change thereof shall be filed with the commissioner...". All Company contracts were reviewed for compliance with these codes. The following is a summary of our findings:

1. The Company currently sells BHP and Healthy Options, and did sell PEBB coverage. A BHP contract was submitted with the Health Care Service Contractor application in 1994, but the Company has not filed updates to the BHP contract or any other contract form or rate. It must immediately file the contracts, handbooks, and rates with the Insurance Commissioner for all current products.

2. As of January 1, 1996, all companies that sell individual plans must have a BHP "look-alike" contract available on a direct, individual basis (RCW 48.44.022). The Company does not have this product. At this time, the Company only sells BHP, Healthy Options, and SSI coverage. If it were to expand to the commercial market, it must have the above listed contract approved and available for sale.

Provider Directory and Annual Filing of Provider Listing

The Company does not have a formal provider directory. It has a list of primary care physicians that is sent out to new members. The listing varies depending on the plan in which the member has enrolled. The listing only includes primary care physicians. The booklet directs the member to call SWMD for additional information or to call 911 in an emergency. In addition, the plan provides a list of participating pharmacies.

The Company did file an annual listing of providers. This list includes those providers that are contracted with SWMC, but do not have a direct contract with the Company. The provider directory and provider listing are both to include only those providers that have a direct contract with the insurance carrier, or who belong to a network that has been rented by the carrier. Since there is not a written agreement between the Company and SWMC to rent the SWMC network, these providers cannot be considered part of the Company's provider network, and therefore do not belong in the directory or on a provider listing. The Company needs to draft an agreement with SWMC to formally "lease" its provider network. Then, it can claim the network as its own.

In one case, a provider listed in the All Categories of Provider annual listing is not contracted with

either the Company or the Hospital (SWMC). All providers listed on this filing must be directly contracted with the Company or must be contracted through an agreement with another entity.

Provider Contracts

The Company uses four provider agreements at this time. They are: Physician Group Agreement, Primary Care Physician Agreement, Referral Physician Agreement, and Hospital Agreement. All have been filed with the OIC and contain the language required by WAC 284-44-240. The following comments from the current contract review apply to all of the filed forms:

The name of the entity contracting with the Company is absent from the body of the form, as is the effective date of the contract. In order to clarify the parties to the contract and the effective date of the contract, both should be added to the body of the document.

Section 2.5 discusses the Company's responsibility in managing enrollees' information and communicating that information to providers. It states that if the provider receives erroneous information from the Company, that the provider must first try to collect any amounts due from the enrollees. If the provider is unsuccessful in recovering costs, the Company will then pay the funds.

Section 2.13 covers coordination of benefits. This section states that the Company will establish and administer the program, but the provider will be responsible for collection of the payments. Since COB requires a single entity coordinating and administering, the Company must be that entity. It must maintain a savings bank, on a calendar year basis, and must determine order of benefit payment, allowable expense and benefit to be paid.

Section 6 of the contract deals with Insolvency Protections. This language does follow WAC 284-44-240. However, the Company has attempted to include the Payor as a party on the same level with the Company. Since the payor is not contracting with the Provider, but is contracting with the Company, this inclusion is not valid. Insolvency on the part of the payor should be a part of the contract between the Company and the payor, only. It needs to be removed from this contract.

The Referral Provider Agreement form has a page that allows the provider to elect (a) capitated payments or (b) non-capitated payments. This is also discussed in Section 3.6. However, after

discussions with the Company, (b) is actually a sub-capitation arrangement, not a fee for service arrangement. Contract language needs to reflect the actual arrangement. In the industry, non-capitation means fee for service. This contract should follow the accepted industry standard. In addition, the term sub-capitation or whatever phrase is penned, should be added to the Section 1, Definitions.

The Appendix titles show the following:

APPENDIX A

REFERRAL PROVIDER AGREEMENT:
CLARK UNITED PROVIDERS/SOUTHWEST WASHINGTON MEDICAL DIRECT
AND PROVIDER

Since SWMD is owned by the Company, the name should not appear on the contract as it gives the appearance that the provider is contracting with both entities. This is not true. Any contracts currently in place with appendixes listing SWMD should be amended to remove any reference to SWMD from the contract.

Specific Provider Contract Review

We requested a sample of 13 provider contracts for review. An additional 3 contracts were requested for review based on information given to the examiners during the claims processing review. The purpose of this review is to confirm that the Company has contracted with the providers shown in its directory, and that the providers have signed a correct contract form. The following findings were noted:

1. Six providers did not have approved provider contracts with the Company. Of these, four did have contracts with SWMC. One is the pharmacy contract that has been revised, but was not filed. The other provider is not contracted with either the Company or SWMC, but does appear on the 1/1/96 all category of provider listing filed with the OIC.

2. Two providers were not contracted on approved provider contract forms. These are American Chiropractic Network and Hi-School Pharmacy.

3. The contract with American Chiropractic Network (ACN) appears to be a fee arrangement to have ACN act as a third party administrator for chiropractic benefits. This appears to be an appropriate arrangement.

4. The provider contracts do not contain the name of the provider, unless it has been added to the final page. To assure that the contract is identifiable, the name of the provider should be substituted for the generic provider type, such as "Physician Group", used in the contract.

5. While the basic provider contract appears to be between the Company and a provider, the name Southwest Washington Medical Direct (SWMD) appears in the headings of some amendments. Since SWMD is owned by the Company, this name should be removed from the contracts.

Conclusion

1. The Company needs to develop and maintain a complete listing of providers to be distributed to members at the time of enrollment, and as changes occur. This list needs to contain only those providers who have a direct contract with the Company or who are part of a network formally contracted. This requirement is set forth in RCW 48.44.080. In addition, this statute requires that monthly updates to the listing be filed with the OIC.

2. The informal arrangement between SWMC and the Company to use the SWMC network needs to be formalized. By doing this, the Company will be able to list the SWMC providers as part of their network.

3. All forms of the provider agreement use a generic provider type instead of the actual provider name. Unless the name is added to the last page of the agreement, it does not appear anywhere in the contract. It is recommended that the Company replace the generic provider type with the name of the provider.

4. The provider agreement (Section 2.13) states that the provider is responsible for pursuing payment information from a third party. It does not distinguish between coordination of benefits and other types of third party liability. WAC 284-51-090 specifically states that the carrier is responsible for obtaining coordination of benefits information. This wording should be removed from the contract, or changed to reflect the differing requirements for different types of liabilities.

Clark United Providers

5. Section 6 of the provider agreements covers insolvency, and contains language mandated by WAC 284-44-240. In this section, the Company has attempted to include the Payor on the same level with the Company. The Payor is not contracting with the provider, therefore, the Payor should not be included in this section. Hold harmless and insolvency between the Company and the Payor should be handled in the agreements between those entities.

6. The Referral Provider Agreement contains an election page on which the provider indicates if it would like to receive capitated or non-capitated payments. This implies that the provider would like to receive a capitated payment or a fee-for-service payment. The Company's definition of non-capitated is not fee-for-service, but an arrangement whereby the provider receives payment based on an RVU (relative value unit) percentage from a pool established by the capitated payment structure from the capitated contracted providers. This language needs to be changed so that actual payment arrangement is elected, and the term is defined in Section 1, Definitions.

7. The contract appendix titles include Southwest Medical Direct (the Division). Since the Division is a part of the Company, this name should not be included as a contracting party.

8. The contract with Hi-School Pharmacy should be revised to include the hold harmless and insolvency language mandated by WAC 284-44-240. This section has been modified from the basic provider agreements. In addition, because this agreement differs from the filed forms, it should be filed with the OIC.

Clark United Providers

AFFIDAVIT OF EXAMINER IN CHARGE

STATE OF WASHINGTON)
)ss
COUNTY OF KING)

Michael V. Jordan, being duly sworn, deposes and says that the foregoing report subscribed by him is true to the best of his knowledge and belief.

He attests that the examination of Clark United Providers was performed in a manner consistent with the standards and procedures required or prescribed by the Washington Office of the Insurance Commissioner and the National Association of Insurance Commissioners (NAIC).

Michael V. Jordan, CPA, CFE
Examiner-in-Charge
State of Washington

Subscribed and sworn to before me this 23rd day of April, 1997.

Colleen Jansen
Notary Public in and for the
State of Washington, residing
at Seattle.